



The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Professions Licensure
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SARP: INITIAL LICENSEE SELF-ASSESSMENT DATA FORM

This form is to be completed by the SARP applicant. Digitally, you may edit the sections highlighted in yellow. You may attach additional sheets as necessary for any section in this form.

NAME:

TODAY'S DATE:

ADDRESS:

DATE OF BIRTH:

AGE:

GENDER:

CONTACT INFO:

LICENSE #:

HOME #:

LICENSE TYPE: ☐ LPN ☐ APN: NA
☐ RN ☐ APN: NM
☐ APN: NP
☐ APN: PC
☐ APN: CRNA
☐ Other:

CELL#:

EMAIL:

SARP REFERRAL SOURCE (check all that apply)

☐ Employer ☐ Self ☐ Family/friend ☐ Physician/provider ☐ Lawyer ☐ Therapist ☐ Police ☐ EAP
☐ Board Investigator ☐ SARP Coordinator ☐ DPH Investigator ☐ Board Committee
☐ Other:

Please explain the events that lead to your referral to the SARP program. You may type in the box below. Please attach a separate sheet if necessary.

Describe your current work or most recent work setting in relation to your drug or alcohol use. Include information on ease of access to drugs, type of structure within the environment, amount and type of supervision available, general environment, and availability of employee assistance personnel.

Summarize your relationship with substances of abuse. Include how this relationship may have led to problems. Please attach additional sheets if necessary.

PLEASE ANSWER THE FOLLOWING:

Have you ever used substances intramuscularly/intravenously?

☐ Yes ☐ No

If yes, did this include needle sharing? ☐ Yes ☐ No

Has substance use ever affected your job (i.e. termination, demotion, etc.)?

☐ Yes ☐ No

Has your has substance use affected your health?

☐ Yes ☐ No

Does your substance use include abusing prescription drugs?

☐ Yes ☐ No

Does your substance use include abusing more than one substance concurrently?

☐ Yes ☐ No

Do you use or have you used substances on a daily or continuous basis?

☐ Yes ☐ No

On a scale from 1 to 5, how severe do you think your alcohol and/or drug problem is? (Check a number.)

Not Severe ☐1 ☐2 ☐3 ☐4 ☐5 **Severe**

OTHER PROFESSIONAL REGISTRATIONS

<i>State</i>	<i>License & license #</i>	<i>License status (e.g active, restricted)</i>

Please list any previous or current complaints against your Professional license, in Massachusetts or another state.

<i>State & board</i>	<i>License & license #</i>	<i>Action & current status</i>

PROFESSIONAL EDUCATION

<i>Program title</i>	<i>School/university</i>	<i>Degree/cert.</i>	<i>Year graduated</i>

CURRENT EMPLOYMENT

<i>Position held</i>	<i>Employer (include supervisor name & #)</i>	<i>Hours/week</i>	<i>Years in position</i>

PREVIOUS EMPLOYMENT HISTORY

<i>Position held</i>	<i>Employer</i>	<i>Years in position</i>	<i>Reason for leaving</i>

Are there any current special practice provisions in place? ☐ No ☐ Yes. If yes, please specify in the space below

Were you terminated from any of your past professional positions? ☐ No ☐ Yes. If yes, for what reason? Please explain in space below. Please attach additional sheets as necessary.

SUMMARY OF CURRENT EMPLOYMENT STATUS: (check all that apply)

- ☐Terminated ☐Leave of Absence ☐Medical Leave ☐Disability Leave ☐Administrative Leave
☐Employed in Profession- Employer is aware of problem ☐Unemployed since:
☐Employed in Profession- Employer is unaware of problem ☐Other:

MEDICAL HISTORY

Please describe significant past and present non-psychiatric medical problems including work-related injuries, chronic illnesses/disorders and surgeries. Please attach a separate sheet if necessary.

<i>Medical problem</i>	<i>Current/historic</i>	<i>Diagnosis date</i>	<i>Treatment</i>

BEHAVIORAL HEALTH HISTORY

Please describe significant past and present psychiatric/behavioral health problems. Please **do not** include any problem or treatment that was only related to drug or alcohol use. Please attach a separate sheet if necessary.

<i>Diagnosis</i>	<i>Current/historic</i>	<i>Diagnosis date</i>	<i>Treatment</i>

If yes, please describe briefly:

Have you ever experienced depression? ☐No ☐Yes

Have you experienced functional impairing anxiety? ☐No ☐Yes

Have you ever experienced panic attacks? ☐No ☐Yes

Have you attempted or thought about suicide? ☐No ☐Yes

If yes, are your providers aware? ☐Yes ☐No

Has anyone in your family ever had a substance use problem? ☐No ☐Yes

➔ **Are you working with a therapist?** ☐Yes ☐No **If yes, what is their name?:**

➔ **If no, are you actively securing one?** ☐Yes ☐No ☐N/A

CURRENT TREATMENT PROVIDERS

<i>Provider name</i>	<i>Specialty</i>	<i>Last visit</i>	<i>Address / Contact information</i>

CURRENT MEDICAL/PSYCHIATRIC MEDICATION

Please identify the medications you are currently prescribed as well as commonly used over-the-counter drugs. Please attach a separate sheet if necessary.

Medication	Presenting symptom	Date first prescribed	Dosage & frequency	Prescriber

PAST/PRESENT LEGAL HISTORY

Please describe the charges and disposition of any legal matters you are involved with:

Have you ever been arrested?

☐ No ☐ Yes

Have you ever been arrested while under the influence of drugs or alcohol?

☐ No ☐ Yes

Have you ever been arrested for possession or distribution of any controlled substances?

☐ No ☐ Yes

Have you ever been incarcerated?

☐ No ☐ Yes

Please explain if you answered yes to any of the legal history questions above. Please attach additional sheets as necessary:

Do you have a lawyer? ☐ No ☐ Yes.

If yes, lawyer's name:

Phone number:

Do you currently have a parole or probation officer? ☐ No ☐ Yes

If yes, officer's name:

Phone number:

Will the officer be requiring communication with SARP? If so, please describe:

COMPULSIVE BEHAVIOR IDENTIFICATION

(check all which you currently feel apply to you)

☐ Substance use

☐ Gambling

☐ Sex/intimacy

☐ Excess food consumption

☐ Excess working/ "workaholic"

☐ Other risk-taking activities

☐ Other:

SUBSTANCE USE SELF ASSESSMENT

Please identify your substance(s) of choice (including alcohol) in order of preference:

Preference	Substance(s) of choice	Age of first use	Place/setting of first use	Date of last use
#1				
#2				
#3				
#4				
#5				

Please check all the boxes that you feel accurately complete this sentence: **"I use a substance(s) to help with...."**

- | | | | | |
|--|--|---|--|--|
| <input type="checkbox"/> Feeling confident | <input type="checkbox"/> Increasing energy | <input type="checkbox"/> Feeling comfortable | <input type="checkbox"/> Feeling relaxed | <input type="checkbox"/> Improving functioning |
| <input type="checkbox"/> Sleep | <input type="checkbox"/> Tolerating the day | <input type="checkbox"/> Socializing | <input type="checkbox"/> Forgetting things | <input type="checkbox"/> Feeling "numb" |
| <input type="checkbox"/> Overcoming loneliness | <input type="checkbox"/> Overcoming emotional pain | <input type="checkbox"/> Overcoming physical pain | | |
| <input type="checkbox"/> Other(specify): | | | | |

IMPACT OF SUBSTANCE USE:

Please answer the questions below regarding the physiologic, social, feeling, behavioral, and other impacts of your substance use:

Physiologic

- | | | |
|--------------------------------|-----------------------------|------------------------------|
| To relieve tension? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Experience increase tolerance? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Consumed more than intended? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Experienced memory lapses? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Social

- | | | |
|--|-----------------------------|------------------------------|
| Attempts to hide substance use? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Continue use after others have stopped? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Others have complained about your use? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Others have felt you have problem use? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| If applicable, your significant other is aware about your use? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| If applicable, you family/friends are concerned? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| If applicable, your significant other knows about your SARP application? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Do you feel....

- | | | |
|--|-----------------------------|------------------------------|
| Guilty about use? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Irritated when use is discussed? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| "Obsessed" about using? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Eager for the next opportunity to use? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Unease when substances not available? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Behaviorally, substance use led you to...

- | | | |
|--|-----------------------------|------------------------------|
| Increase spending to obtain the substance(s)? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Do something illegal to obtain a substance(s)? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Behave differently than if you were sober? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Have you ever made any conscious attempt(s) to stop your alcohol/drug use? ☐ No ☐ Yes, please identify below.

Date of attempt	Method/significant information	Length of sobriety

WITHDRAWAL HISTORY

Have you ever experienced any of the following signs/symptoms during any substance use withdrawal? (check all that apply)

- | | | | | |
|---|---------------------------------------|---|---------------------------------------|---|
| <input type="checkbox"/> Elevated vital signs | <input type="checkbox"/> Anhedonia | <input type="checkbox"/> Dizziness/light-headedness | <input type="checkbox"/> Flushing | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Lowered vital signs | <input type="checkbox"/> Seizures | <input type="checkbox"/> Depression | <input type="checkbox"/> Nausea | <input type="checkbox"/> Urges/cravings |
| <input type="checkbox"/> Emesis | <input type="checkbox"/> Fever | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Restlessness | <input type="checkbox"/> Diaphoresis |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Piloerection | <input type="checkbox"/> Excess yawning | <input type="checkbox"/> Photophobia | <input type="checkbox"/> Hallucinations-Tactile |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Myalgia | <input type="checkbox"/> Arthralgia | <input type="checkbox"/> Ostealgia | <input type="checkbox"/> Hallucinations-Auditory |
| <input type="checkbox"/> Insomnia | | <input type="checkbox"/> Abdominal cramps | | <input type="checkbox"/> Hallucinations-Visual |
| <input type="checkbox"/> Other: | | | | <input type="checkbox"/> Hallucinations-Olfactory |

Have you ever participated in structured mental health or substance use withdrawal services? ☐ No ☐ Yes, please identify below. Please attach a separate sheet if necessary.

Dates	Program name & location	Length of treatment	Treatment type (select one per row)
			<input type="checkbox"/> Inpatient <input type="checkbox"/> Intensive outpatient <input type="checkbox"/> Supervised withdrawal services ("detox") <input type="checkbox"/> Counseling/groups <input type="checkbox"/> Transitional living
			<input type="checkbox"/> Inpatient <input type="checkbox"/> Intensive outpatient <input type="checkbox"/> Supervised withdrawal services ("detox") <input type="checkbox"/> Counseling/groups <input type="checkbox"/> Transitional living
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			<input type="checkbox"/> Inpatient <input type="checkbox"/> Intensive outpatient <input type="checkbox"/> Supervised withdrawal services ("detox") <input type="checkbox"/> Counseling/groups <input type="checkbox"/> Transitional living

INVOLVEMENT IN RECOVERY GROUPS

Please describe your historic & current involvement with the self-help groups below. Please note "N/A" if appropriate.

Self-help group	Current or historic involvement	Currently attend
Alcoholics Anonymous		# of mtgs/week:
Narcotics Anonymous		# of mtgs/week:
Professional Support		# of mtgs/week:
A Way of Life (AWOL)		# of mtgs/week:
SMART Recovery		# of mtgs/week:
Moderation Management		# of mtgs/week:
Other:		# of mtgs/week:

Do you have a sponsor? ☐ No ☐ Yes, first name: Contact frequency: ☐ daily ☐ weekly ☐ monthly

Do you have a home group? ☐ Yes ☐ No Location & name of group:

How often do you attend the following kinds of meetings? (Please provide number of meetings per week.)

☐ Big Book mtgs:
 ☐ Discussion mtgs:
 ☐ Step mtgs:
 ☐ Other: